

**DISTRICT OF COLUMBIA**  
**Office of Administrative Hearings**  
One Judiciary Square  
441 4th Street, NW, Suite 450N  
Washington, DC 20001-2714  
Tel: (202) 442-9094 • Fax: (202) 442-4789  
Email: [oah.filing@dc.gov](mailto:oah.filing@dc.gov)

**REQUEST FOR HEARING IN OFFICE OF PAID FAMILY LEAVE CASE**

**SECTION 1 – CONTACT INFORMATION**

Name (please print): \_\_\_\_\_ Attorney/Representative (if any): \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION 2 – Office of Paid Family Leave Determination/REASON FOR HEARING REQUEST**

I am appealing and have attached a copy of the:

- claims examiner determination** Date of determination: \_\_\_\_\_  
 **determination on reconsideration (if any)** Date of determination: \_\_\_\_\_

*Note: An appeal must be filed with OAH within sixty (60) calendar days after the date the claim determination or determination on reconsideration is issued.*

**PLEASE INDICATE THE TYPE OF DETERMINATION YOU ARE APPEALING.**

- Whether Claimant may receive benefits** under the Universal Paid Family Leave program  
 **Weekly amount of benefits** payable to Claimant under the Universal Paid Family Leave program  
 **Date payment shall begin** to Claimant for Universal Paid Family Leave benefits  
 **Number of weeks** Claimant may receive Universal Paid Family Leave benefits  
 **Provisional denial** of claim for Universal Paid Family Leave Benefits

Please include a brief description of why you disagree with the determination:

\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3 – LANGUAGE ACCESS**

Do you need language interpretation?

- YES  NO

If YES, specify language: \_\_\_\_\_

**SECTION 4 – ACCOMMODATIONS FOR DISABILITY**

Do you need reasonable accommodation for disability at hearing?

- YES  NO

If YES, please specify: \_\_\_\_\_

**SECTION 5 – CLAIMANT SIGNATURE**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_